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presence of acquired disease in pregnant women, and the statistical incidence of significant malformations in the fetuses can be predicted.[8, 24] However, a problem may arise from the medico-legal implications of terminating a pregnancy in which the fetus was not damaged by the infection. The second solution is to identify susceptible women and advise them to avoid situations where there is a greater possibility of being exposed to rubella infection. This means of coping with the problem can be implemented immediately.

Experience has shown that a history of rubella in individuals is unreliable in assessing their immune status.[7, 25] Fortunately, available laboratory techniques allow the identification of persons who are susceptible to rubella infection, specifically the neutralization antibody tests such as the hemagglutination inhibition test.[26, 27]

How frequently do we encounter a young married nurse who continues to work in the hospital nursery or some other area where she is exposed to these infants with rubella syndrome and who are excreting the living virus?[28] Many of these young women continue to work when they are pregnant. Surely such mothers, if they are susceptible to rubella infection, are exposing their own fetuses to an unreasonable risk. Other female hospital personnel may also be at risk. It is only reasonable and fair to inform these young women of the risk to the fetus in their work situation.

It is suggested that all women of child-bearing age should have their immune status to rubella disclosed by the hemagglutination inhibition test. Susceptible women should then be advised to avoid high-risk situations if they are pregnant or anticipating pregnancy. Infants with rubella embryopathy syndrome should be identified and isolated from pregnant women. Since these infants may be infectious for many months, some control of their mobility will be required after they leave hospital.

I hope this communication will stimulate medical and nursing professional organizations to study the problem of rubella embryopathy and congenital malformation and formulate additional recommendations for its prevention.

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DRUG COSTS

To the Editor:

The recent correspondence in the Journal on drug costs (*Canad. Med. Ass. J.*, 100: 440, 1969) is taking on a cantankerous and rather distressingly pseudostatistical overtone. The suggestion that the discovery of one usable drug by pharmaceutical firms represents an investment in research of seven million dollars and the method of calculation of this figure remind me of statistical manipulation, e.g. "If all the girls in Las Vegas were laid end to end—I shouldn't be at all surprised!"

I also cannot help feeling it is a little egregious of Dr. Wigle to suggest that the pharmaceutical industry "has probably done more for mankind through the saving of lives and relief of suffering in the past 30 years than any other industry in history". He is arbitrarily abrogating to the pharmaceutical industry all the advances in pharmacology and biochemistry that have occurred in the past generation. The age of miracles is no more due to one industry than it is due to one discipline or to one man.

The pharmaceutical industry is suggesting that the development of new drugs is largely dependent upon the present financial structure of the industry in Canada. I would sincerely like to know the answer to this question: Does Canada with its system of financial reward to pharmaceutical manufacturers produce more useful drugs than countries that do not have this system but are of a comparable development? I would suggest that this is in fact the crux of the situation. I do not feel that Dr. Wigle is justified in being surprised at the attitude towards pharmaceutical manufacturers. If he will remember they have been under a great cloud of suspicion for a very long time. While Canada is not the United States, nevertheless the senatorial committee that investigated drug costs

in the States some years ago had its effect on many people's thinking (the Kefauver Report).

Finally, Dr. Wigle says that the Pharmaceutical Manufacturers Association of Canada is concerned about a radical increase in the number of unproved products and that it feels that Canadians have a right to expect that every product has proved clinical efficiency. I don't think anybody could disagree with this, but nor do I think that the present pharmaceutical set-up guarantees it—witness the number of unproved drugs that are marketed every year (including thalidomide). If this is indeed their concern, why do they not take some of the money that they have been making and finance an organization to "prove" all drugs before they are marketed, an organization that would have the authority of the Food and Drug Administration plus better financing. We seem continually to ignore the fact that what is needed is an objective and independent analysis of what is safe and what is clinically effective. It is not enough to leave this in the hands of interested parties.

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C.M.A.–C.E.S.O. PLAN

To the Editor:

Dr. Elinor F. Black, former Professor of Obstetrics and Gynecology at the University of Manitoba in Winnipeg, has returned to Canada after completing a three-month volunteer assignment in Jamaica under the combined auspices of The Canadian Medical Association and Canadian Executive Service Overseas.

The first C.M.A.-C.E.S.O. Plan volunteer to serve in Jamaica, Dr. Black was posted to the University of the West Indies in Kingston as a visiting professor. There she assisted with undergraduate and postgraduate teaching in obstetrics and gynecology and with the clinical work at the University Hospital during the absence of the Head of the Department, Professor David Stewart.

Since it went into operation less than a year ago, the joint C.M.A.-C.E.S.O. Plan has enabled over 20 Canadian doctors to serve in several islands in the West Indies, relieving otherwise irreplaceable and overworked medical personnel, usually for periods of from one to three months.

Under this co-operative arrangement, The Canadian Medical Association selects the doctors, who serve without remuneration. The host government or institution furnishes accommodation and Canadian Executive Service Overseas is responsible for travel costs.

Unlike the average tourist who makes a useful contribution to the islands' economy, and in return brings back a tropical tan, straw baskets and memories of happy hours on white beaches, the returning doctors retain a slightly different picture.

Their long days in the islands are filled with hard work. In the short time they are there, they treat an amazing number of patients, with long queues of native children and their mothers awaiting attention. Often there is a shortage of drugs and equipment. However, the visiting Canadian doctors are unanimous in expressing admiration for the devotion and competence of the local staff, who frequently work under difficulties.

Dr. Elinor Black has made a valuable contribution to the C.M.A.-C.E.S.O. Plan program in the West Indies. She reports having had an extremely busy three months in Jamaica but that it was "most interesting" and that she enjoyed the beauty of the island tremendously.

EILEEN WHILLANS

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[EDITOR'S NOTE: Physicians interested in volunteering their services in a similar manner (all expenses are paid for the physician and his wife) are requested to contact Dr. A. D. Kelly, C.M.A. House, 150 St. George Street, Toronto 5.]

THE "SATURDAY NIGHT SYNDROME"

To the Editor:

Dr. A. B. Adey's letter on "The 'Saturday Night Syndrome'" in the March 15 issue (*Canad. Med. Ass. J.*, 100: 539, 1969) elicited the following free association. I started singing the old song "Saturday Night Is the Loneliest Night of the Week," and then I saw and heard myself, in my mind's eye and ear, seated at a piano trying to compose a new ballad called "Saturday Night Is the Busiest Night of the Week". Suddenly from out of the dormant medical-school-anatomy past came the memory of "Saturday night paralysis". Yes, indeed, Saturday night is a busy time for clinical syndromes!

"Saturday night paralysis" is a well-known compression nerve palsy. This radial paralysis usually results from sleeping with an arm hanging over the back of a chair—a picture-book posture of the Saturday night inebriate—giving rise to a wrist drop. Radial palsy resulting from pressure on the nerve against the edge of a chair or bed during alcoholic stupor is apparently less common today than formerly. Nevertheless, Saturday night palsy has priority as the original "Saturday night syndrome". Dr. Adey's popcorn eaters, six boys from 6 to 12 years of age who developed unusual "bad tummies" following the exuberant ingestion of dry-heated Indian corn at a local movie theatre, are probably better labelled under the term he introduces: "popcorn ileus".

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